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THE TRAINING SCHOOL BULLETIN

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1. Articles of a technical nature, e. g., reports of research, discussion of problems in the field.
2. Non-technical articles of general interest, e. g., human interest stories of the mentally retarded, restatements of technical material for the layman.
3. Book reviews and news notes.
4. In special instances republication of important articles having limited distribution.

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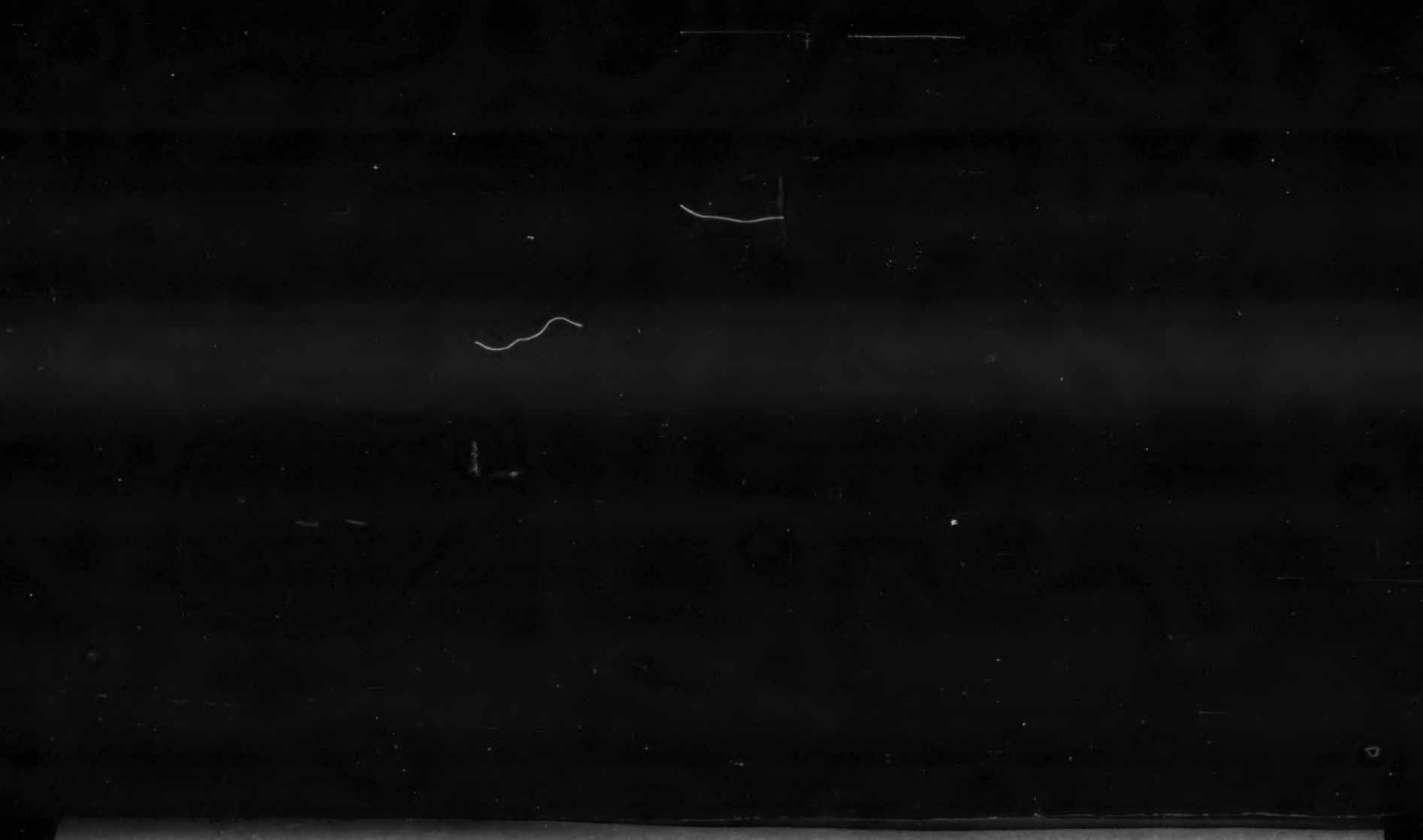

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APPLICATIONS OF CLINICAL PSYCHOLOGY TO MENTAL DEFICIENCY

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Reprinted from Volume II, Chapter 33, *Progress in Clinical Psychology* by Brower and Abt. NEW YORK: Grune and Stratton, 1952.

Unlike the field of mental illness which has shown a tremendous growth in public interest and professional opportunity during the past decade, the field of mental deficiency, by comparison, has appeared to regress. Fortunately, however, the long-term social value of any field of scientific endeavor is not measured by the number of workers in it nor the volume of literature. Rather, it is measured by the relatively few, rare discoveries and new points of view which enable further sound work to be done. In this sense, the field of mental deficiency has made rapid progress during the past few years, and the outlook for the future is encouraging.*

The criteria for mental deficiency depend upon one's point of view. Probably the most popular definition of mental deficiency hinges on intellectual function or efficiency as measured by a standardized psychological test of intelligence. Within the range of IQs from 0 to 70, it is conventional to think of three categories: Idiot, Imbecile and Moron. The very simplicity of this psychometric definition has had unfortunate results. It imputes a totally unreasonable omniscience to the intelligence test, a power which has been seldom, if ever, claimed by test constructors. This definition assumes, also, a greater constancy in the IQ than has been demonstrated, and it neglects the broad practical problems in such areas as the physical, medical, social and personality development and function. Although the psychometric approach has been of considerable value in regard to such problems as classification and education, it has serious limitations as the sole criterion for mental deficiency.

* No student of the subject can afford to overlook the broad treatments of the field by such authorities as Tredgold,[43] Penrose[35] and Doll.[14] A basic bibliography on mental deficiency by French[18] is a useful guide to the field.

The psychometric criteria have been concerned with the individual's rank in the population in regard to performance on intelligence tests. The IQ range of 70 to 80 is generally accepted as the area which separates mental deficiency from normality. There is no particular rationale for choosing the IQ of 70 as the absolute lower limit of normality; it is merely an arbitrary figure. There is no assurance that an IQ of 70 from one test is comparable with an IQ of 70 from some other scale since, among other things, standard deviations vary from test to test. It seems reasonable to believe that one day there may be general agreement on a statistical definition of mental deficiency and on a standard deviation to be used for tests of intelligence. Then it would be possible to say that only those who fall so far below the mean, two SDs for example, may be called mentally defective.

Jastak[23] gives "rigorous" criteria for diagnosing mental deficiency; he requires failure to surpass the lowest three per cent of the population in 12 or more different functions. No doubt, a child classified as mentally deficient by Jastak would be similarly diagnosed by all other authorities, but there is also no doubt that Jastak's formula would exclude a very large number of cases diagnosed as feebleminded by other specialists.

More satisfactory is a definition which stresses social incompetence due to arrest, for whatever cause, of the development of intellectual capacities and efficiency. Doll[12] uses such a definition, though he limits its application to those individuals in whom the deficiency is present at maturity, or is predicted to be present at that time. Doll (and the majority of authorities agree with him) considers true mental deficiency to be a life-long, irremediable handicap.

The social criteria are concerned chiefly with adjustment and self-direction. It is quite common for the maladjusted or delinquent individual who exhibits faulty social judgment to be called mentally defective even if his IQ is in the dull normal range between 80 and 90. This confusion of social and intellectual deficiency is partly due to the tendency to find a diagnosis which will enable one to give a particular individual the kind of treatment which is thought to be most beneficial to society. According to this social definition, an individual with IQ of 60 would almost inevitably be called mentally deficient in a modern, urban environment whereas he might not be thought defective if he seemed to make a satisfactory social adjustment in an environment in which the social and vocational demands were limited and simple.

These definitions, the psychometric and the social, illustrate the two major areas of concern with the problem of mental deficiency. The former was the natural outgrowth of the work of the educators and their psychological collaborators whose objectives were in terms of educational classification and measurement of intellectual performance. The latter definition illustrates society's concern with management of a serious social problem in a complex competitive environment. In considering the criteria for mental deficiency, it is well to remember, as McCulloch[31] points out, that the term mental deficiency generally represents an administrative grouping which changes with community or social requirements; that the association between intellectual and social competence is low among the higher grade defectives and that prognoses vary widely.

For many years there has been a general tendency to classify defectives into two major groups: one due to heredity, and the other to environment. The classification scheme in general use has labels of endogenous and exogenous which correspond to the heredity-environment dichotomy. Closely akin to endogenous and exogenous, as classification terms, are such frequently used terms as familial and brain damaged.

It is quite possible that with further increases in knowledge, the classification scheme proposed by Lewis[27] in 1933 will find wider use. Lewis suggested the division of defectives into "pathological" and "subcultural" types. The disease or conditions which produce the pathological type might be hereditary or environmental and could be so sub-divided. It is a fact that there are more idiots and imbeciles in the population than one would predict according to the normal curve of distribution of intelligence. Most of the cases have obvious neuropathology or brain damage and would fit into Lewis' "pathological" group. Other defectives, which might be expected according to the normal distribution of intelligence would belong to the "subcultural" group.

From the medical point of view, most mental defectives are to be described according to physical symptoms, disease processes and the causes of the condition. Thus, it is of more significance to call an individual a mongoloid, or a microcephalic, than it is to say that his IQ is 45 and his capacity for social adjustment is defective. There is much to say for Lurie's[30] statement that there has been too much emphasis on intellectual and social adequacy in the concepts of mental deficiency, as

the result has been to consider it a distinct clinical entity. Lurie defined mental deficiency as a symptom associated with an underlying constitutional disturbance which may be remediable. There can be no doubt that organic factors are responsible for a large proportion of cases, but whether these factors are genic, prenatal, paranatal, or postnatal in their operation is of considerable significance. The medical view is represented by Yannet[45] who recommends the following 12 etiologic categories, which are said to encompass 70 percent of institutionalized mental defectives: 1. Familial defective; 2. Cerebral palsy; 3. Mongolism; 4. Epilepsy; 5. Infection; 6. Trauma; 7. Craniofacial defects; 8. Phenylpyruvic amentia; 9. Cerebral lipoidosis; 10. Cretinism;

Although the literature rather generally has implied a dichotomous etiology in which endogenous cases are supposed to be physically normal and the exogenous organically damaged, Benda[7] has reported his findings, through two hundred autopsies, of definite neuropathology in the brains of familial defective or endogenous children.

The significance of birth injuries or paranatal factors as causes of mental deficiency has been a major topic for twenty years. A broad discussion of birth injuries, infections, toxic process, prematurity, asphyxia, hemorrhages and trauma of the skull is given by Alpers.[1]

Certain conditions such as prolonged labor and eclampsia are associated with lower IQs in children according to Battle[5] who studied the birth records of 453 high school pupils. But normal delivery at full term does not preclude serious intracranial birth injury, according to de Lange.[11] It can not be assumed that brain injury always means mental deficiency or retardation. More attention has been given recently to the development of methods to determine to what extent the organic defects of the brain injured result in mental deficiency (Krout[24]).

It is to be expected that there will be rapid development of knowledge of the relationship between specific pathologies of the brain and intellectual deficiencies. Such findings as those of Wortis, et al.[44] who found disturbance of abstract thinking and reduction of spontaneous ideation in cases of subdural hematoma are significant. Study of epilepsy may shed more light on brain function. Although 64 per cent of 1900 extra-mural cases of epilepsy were classified as not mentally defective, Lennox[25] found a relationship between seizure frequency and mental retardation.

Of recent years there has been much interest in the role of blood types and the Rh factor. Yannet and Lieberman[46] discovered the possibility that A and B iso-immunization or maternal ABO incompatibility is a significant factor in the etiology of the undifferentiated cases of deficiency. Despite some negative findings, several investigators have found evidence for the Rh factor as one of the contributors, at least, to mental deficiency.

There is mounting evidence for the damaging effects of whooping cough, early in life (Levy and Perry[26]) and of maternal measles early in pregnancy. Studies by Packer[33] and Patrick[34] indicate rather conclusively that maternal German measles in the early months of pregnancy result in a high incidence of various disorders such as deafness, mutism and different kinds of mental deficiency. It would appear that German measles is less deleterious in its effects than is whooping cough.

Mongolism continues to be a baffling problem although progress has been made toward discovering the conditions under which it appears. Ingalls[22] gives the evidence for the etiologic effects of acute infections, lack of oxygen in the fetus, uterine hemorrhage, threat of abortion and other uterine pathologies as causes of mongolism. Engler,[16] who gives perhaps the most authoritative review of the problems, believes that toxic and infectious processes produce mongolism and suggests the importance also of chemical or mechanical attempts at abortion. In mongolism, as in other conditions, the identification of specific causes of particular conditions, however, is not considered to be a reasonable objective at the present time; the main condition may be produced by a great variety of causes, while the same cause, under different circumstances, may result in a wide variety of conditions. Penrose writes "the point of time in embryonic development at which the disturbance is produced seems to be more important, in determining the resulting type of malformation, than the exact nature of the agent."[35] While this statement had to do with the cause of malformations, it is probably revelant to the organic and prenatal causes of many forms of mental deficiency.

Accurate diagnosis is unusually important wherever there is a question of brain damage. The work of Strauss and Lehtinen[41] is eminent in this area. Doll[15] calls attention to the possibility of identifying a brain injured group for whom the prognosis is good under appropriate treatment. He suggests the new diagnostic term, "neurophrenia," for

such cases. Diagnosis of brain damage are made through conventional neurological examinations, psychological tests, observational studies of behavior and through the instrumental means provided by electroencephalography (EEG) and pneumoencephalography. The EEG has found much favor as an aid to diagnosis even though the method has by no means been standardized or validated. Greenblatt, et al.[20] found EEG readings from the base of the brain unusually good for detecting gross intracranial pathology. According to Liberson,[28] there are EEG indicators of certain relationships between idiopathic epilepsy, mental retardation and childhood abnormalities; and Cain and Corriol[9] found a relationship between EEG data and psychometric findings with deficient but reeducable children.

There has been continuing activity among psychologists in the attempt to refine testing techniques and to find special uses for them. The Porteus mazes have had less general use in clinical practice in recent years but there is considerable evidence now of their value is assessing the effects of psycho-surgery (Porteus[36]). The Rorschach technique has been among the most popular, but least validated, of clinical tools (Benton[8]) and it has been used increasingly in the field of mental deficiency.

The Oseretsky tests have shown the relationship between intelligence and motor proficiency in groups with no evidence of organic pathology (Sloan[39]). There is thus an implication of a neuromuscular basis or accompaniment of mental deficiency in spite of negative neurological findings. The Gesell[19] method of developmental diagnosis is claimed both to indicate minimal cerebral injuries and the probability of true mental deficiency at the early age of 16 to 20 weeks.

In addition to diagnosis by means of the IQ, the Stanford-Binet Form L has been reported by Thompson and Magaret[42] to have 30 items which distinguish between defective and normal children of equal mental age.

In the area of diagnostic testing there has been a notable increase in the conception that psychological tests are to be viewed as instrumental means toward limited goals, if used by well-trained and competent psychologists (Estes[17]) and that their value depends more upon the competence of their users than upon their own intrinsic merits.

Another conception which must be considered in relation to the physical, social and psychological criteria discussed above is that mental deficiency is irremediable. Thus, the diagnostician is concerned not only with the observation that the intellectual functions are now defective but with the possibility that the efficiency of intellectual functioning may increase to such an extent that at some future time the diagnosis of mental deficiency could not be made. In such cases the competent examiner would place much emphasis upon the reasons for the present deficiency and the circumstances under which the deficiency may be ameliorated.

We know that there are many conditions which simulate deficiency but should not be confused with it, e. g., early schizophrenia. It is no longer acceptable in professional practice to base a diagnosis of mental deficiency solely upon intelligence test scores or academic failure. Many authorities have called attention to the need to make a careful distinction in diagnosis between mental deficiency, mental retardation and pseudofeeblemindedness. Doll[13] calls attention to motor proficiency, personality dynamics, somatic attributes, mental patterns and, especially, to social competence in differential diagnosis. Many other writers have discussed this problem in recent years, among them Arthur[3] and Bakwin.[4]

Within the recent past there has developed a comparatively new point of view toward mental deficiency which may, in a sense, revolutionize the field. This is due to a concern with psychodynamics which has had profound influence in clinical psychology and psychiatry. Whereas we have traditionally thought of mental deficiency as a disease or a condition, we are now beginning to think of it as a symptom complex or a process which may have many causes. The emphasis is changing from intelligence as a central problem to the subject of personality as a whole. This viewpoint has already enabled us to find that many children of nondefective intellectual power and capacity have been misdiagnosed as feebleminded because they obtained low IQs in certain psychological examinations. That is, much pseudo mental deficiency is caused by personality disorders. For example, Neuer,[32] in a study of 300 mentally defective children divided them into two groups: one, characterized by organic pathology, and the other, by neuropsychiatric problems. It was stated that emotional disturbances and inferior cultural standards might have produced the moron group and that

mental deficiency in neurotic or psychotic children is the result, rather than the cause, of the personality disorder. The evidence for the importance of understanding personality disorders among truly or supposedly mentally deficient children is now unquestioned. It seems quite possible that the type of marasmus discussed by Ribble[37] should be considered as one of the causes of some cases of mental retardation.

Consideration of the problems of therapy raises the question of treatment of mental deficiency per se or treatment of persons who are diagnosed as being mentally deficient. For many cases, of course, treatment is generally planned through medical means. As examples of this approach, one might cite such methods as the use of thiamin, cerebral galvanization, shock therapy and glutamic acid. There has been a great deal of controversy over the effectiveness of glutamic acid therapy. A review of the literature by Arbitman[2] leads to considerable scepticism about the positive effects which have been claimed. Another approach to treatment is the operative procedure of revascularization of the brain which is reported by Beck, et al.[6] to have positive effects on a majority of children.

Despite the earlier pessimism there can be no doubt now as to the effectiveness of counseling and psychotherapy with the mentally deficient and with the personality disorders of many who have been mistakenly diagnosed. An authoritative discussion of the problem is given by Sarason.[38] Successful psychotherapeutic projects have been reported by psychologists, social workers and educators (Cotzin,[10] Harms,[21] Lovell and Ingram[29]).

It is the opinion of many authorities that mental deficiency is a neglected field, characterized by a generally low level of work in all its areas (Stevenson[40]). This has been due, in part, to a pervasive scepticism as to treatment and prevention and, in part, to a lack of professional training and financial support for research in the field. It may now be expected that an awakening interest and concern will lead to more public and private support for research in the field of mental deficiency.

REFERENCES

1. Alpers, B. J. Cerebral birth injuries. In S. Brock, *Injuries of the brain and spinal cord and their coverings.* Baltimore, Williams & Wilkins, 1949, Pp. 229-256.
2. Arbitman, H. D. The present status of glutamic acid therapy for mental deficiency. *Train. Sch. Bull.*, 1952, 48, 187-199.
3. Arthur, Grace. Pseudo-feeblemindedness. *Amer. J. ment. Def.*, 1947, 52, 137-142.
4. Bakwin, H. Feeblemindedness and pseudofeeblemindedness, *J. Pediat.*, 1950, 271-280.
5. Battle, Margaret. Effect of birth on mentality. *Amer. J. Obstet. Gynaec.*, 1949, 58, 110-116.
6. Beck, C. S., McKhann, C. F. and Belnap, W. O. Revascularization of the brain. *Amer. J. ment. Def.* 1950, 55, 218-219.
7. Benda, C. E. Ten years research in mental deficiency; a study based on 200 autopsies. *Amer. J. ment. Def.*, 1946, 51, 170-185.
8. Benton, A. L. The experimental validation of the Rorschach test. *Brit. J. med. Psychol.*, 1950, 23, 45-58.
9. Cain, J. and Corriol J. Etude EEG d'un groupe d'enfants deficients reeducacables: confrontation des resultats electroencephalographiques, cliniques et psychotechniques. *EEG clin. Neurophysiol.*, 1950, 2, 103-104.
10. Cotzin, M. Group psychotherapy with mentally defective problem boys. *Amer. J. ment. Def.*, 1948, 53, 268-283.
11. de Lange, Cornelia. On serious birth injuries of the brain after normal delivery a terme. *Acta paediatr. Stockh.*, 1950, 39, 179-191.
12. Doll, E. A. Definition of mental deficiency. *Train. Sch. Bull.*, 1941, 37, 163-164.
13. Doll, E. A. Feeblemindedness vs. intellectual retardation. *J. educ. Res.*, 1947, 40, 569-573.
14. Doll, E. A. The feebleminded child. In L. Carmichael (Ed.) *A manual of child psychology.* New York: John Wiley and Sons, 1946.
15. Doll, E. A. Neurophrenia. *Amer. J. Psychiat.*, 1951, 108, 50-53.
16. Engler, M. *Mongolism (peristatic amentia).* Baltimore: Williams & Wilkins, 1949.
17. Estes, S. G. Psychometrics. *Amer. J. Psychiat.*, 1951, 107, 514-515.
18. French, E. L. A basic bibliography in mental deficiency. *Train. Sch. Bull.*, 1950, 47, 64-67.
19. Gesell, A. L. Differential diagnosis of mental deficiency in infancy. *Neb. St. med. J.*, 1947, 32, 304-307.
20. Greenblatt, M., Funkenstein, D., Miller, D. and Rinkel, M. Electroencephalographic patterns from the base of the brain. *Amer. J. Psychiat.*, 1947, 103, 749-757.
21. Harms, Mary. Case work with adult mental defectives in a placement program. *Amer. J. ment. Def.*, 1947, 51, 510-518.
22. Ingalls, T. H. Etiology of Monoglism: epidemiologic and teratologic implications. *Amer. J. Dis. Child.*, 1947, 74, 147-165.
23. Jastak, J. A rigorous criterion for feeblemindedness. *J. abnorm. soc. Psychol.*, 1949, 44, 367-378.

24. KROUT, M. H. Is the brain-injured a mental defective? *Amer. J. ment. Def.*, 1949, 54, 81-85.

25. LENNOX, W. G. Mental defect in epilepsy and the influence of heredity. *Amer. J. Psychiat.*, 1942, 98, 733-739.

26. LEVY, S. AND PERRY, H. A. Pertussis as a cause of mental deficiency. *Amer. J. ment. Def.*, 1948, 52, 217-226.

27. LEWIS, E. O. Types of mental deficiency and their social significance. *J. ment. Sci.*, 1933, 79, 298.

28. LIBERSON, W. T. Electroencephalography. *Amer. J. Psychiat.*, 1951, 107, 510-514.

29. LOVELL, C. AND INGRAM, C. P. A high school program for mentally retarded adolescent girls. *J. educ. Res.*, 1947, 40, 574-582.

30. LURIE, L. A. The medical concept of feeblemindedness. *Amer. J. ment. Def.*, 1946, 50, 512-515.

31. MCCULLOCH, T. L. Reformulation of the problem of mental deficiency. *Amer. J. ment. Def.*, 1947, 52, 130-136.

32. NEUER, H. The relationship between behavior disorders in children and the syndrome of mental deficiency. *Amer. J. ment. Def.*, 1947, 52, 143-147.

33. PACKER, A. D. The influence of maternal measles (morbilli) on the unborn child. *Med. J. Aust.*, 1950, 1, 835-838.

34. PATRICK, P. R. Report of a survey of children born in 1941 with reference to congenital abnormalities arising from maternal rubella. *Med. J. Aust.*, 1948, 1, 421-425.

35. PENROSE, L. S. *Biology of mental defect.* New York: Grune and Stratton, 1949.

36. PORTEUS, S. D. *The Porteus Maze Test and Intelligence.* Palo Alto, Calif.: Pacific Books, 1950.

37. RIBBLE, MARGARET A. Infantile experience in relation to personality development. In J. McV. Hunt (Ed.), *Personality and the behavior disorders.* Vol. II. New York: The Ronald Press Co., 1944, Pp. 621-650.

38. SARASON, S. B. *Psychological problems in mental deficiency.* New York: Harper, 1949.

39. SLOAN, W. Motor proficiency and intelligence. *Amer. J. ment. Def.*, 1951, 55, 394-406.

40. STEVENSON, G. S. Where and wither in mental deficiency. *Amer. J. ment. Def.*, 1947, 52, 43-47.

41. STRAUSS, A. A. AND LEHTINEN, LAURA E. *Psychopathology and education of the brain-injured child.* New York: Grune and Stratton, 1947.

42. THOMPSON, CLARE W. AND MACARET, ANN. Differential test responses of normals and mental defectives. *J. abnorm. soc. Psychol.*, 1947, 42, 285-293.

43. TREDGOLD, A. F. *A testbook of mental deficiency* (7th Ed.), London: Bailliere, Tindall and Cox, 1947.

44. WORTIS, S. B., HERMAN, M. AND LONDON, J. Mental changes in patients with subdural hematomas. *Res. Publ. Ass. nerv. ment. Dis.*, 1945, 24, 274-282.

45. YANNET, H. Diagnostic classification of patients with mental deficiency. *Amer. J. Dis. Child.*, 1945, 70, 83-88.

46. YANNET, H. AND LIEBERMAN, ROSE. Further studies of ABO isoimmunization, secretor status and mental deficiency. *Amer. J. ment. Def.*, 1948, 52, 314-317.

ARTICLE ON TRAINING SCHOOL APPEARS IN BRIEF MAGAZINE

The February 1953 issue of BRIEF Magazine carries a picture story and article by Pearl S. Buck concerning The Training School at Vineland. Twelve excellent pictures of children and activities at the school are depicted.

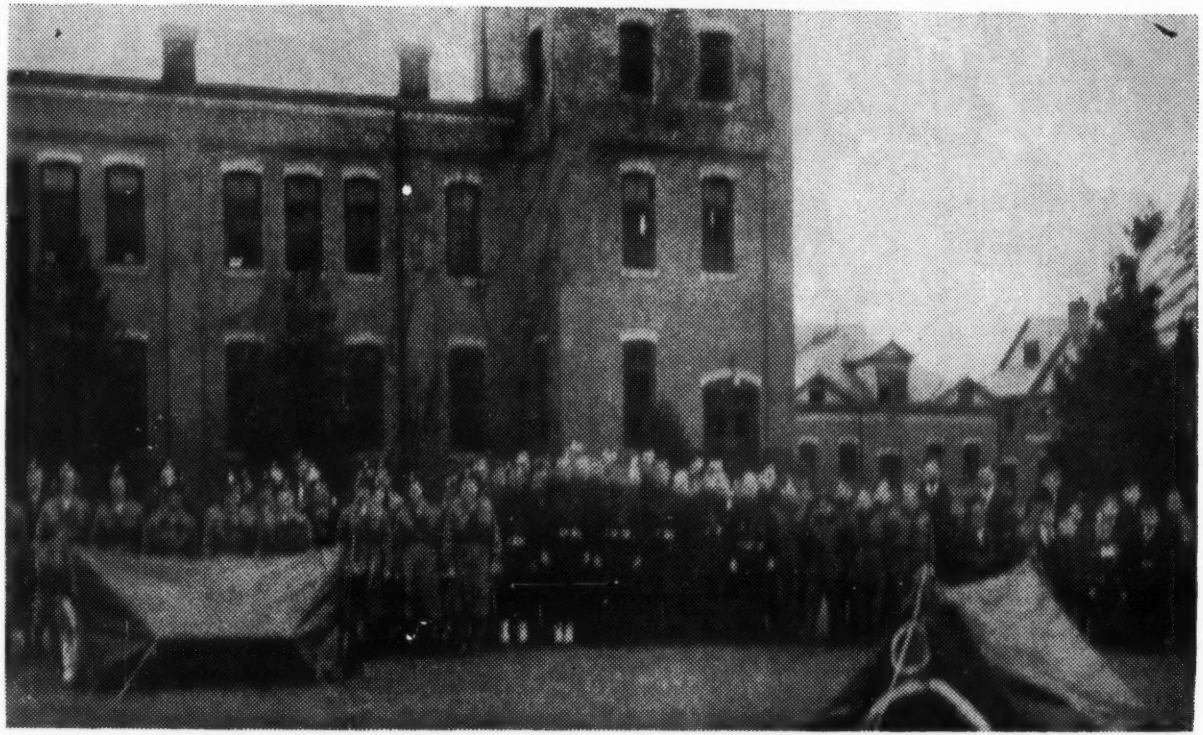
Titled "The Innocent", the article is the opening one in the magazine, starting on Page 2. Paul G. Schutzer, well known photographer, was invited to The Training School in August 1952 on this special assignment. After seeing his pictures, the editor of the magazine, Robert Levin, took them to Pearl S. Buck who agreed to write the text.

In the article, the author states: "There is no child, I believe, who is so retarded that he cannot be taught something or who cannot become a useful member of some community suited to his needs".

BRIEF, a new magazine about the size of Coronet or Pageant, is published at 270 Park Avenue, New York, 17, New York. It is available at most major news stands.

AMONG OUR VISITORS

Recent visitors to The Training School include H. P. Maiti, professor of Applied Psychology and director of Psychological Research at Patna University, India; Miss Aida Correa Nunes, psychologist and teacher at the Ferreira Institute, Lisbon, Portugal; Mrs. Maurice Zinkin of India, correspondent for the London Economist and Illustrated Weekly; Earl Ubell, science writer for the New York Herald Tribune; Salvatore G. Di Michael, from the office of Vocational Rehabilitation, Federal Security Agency, Washington, D. C.; Lazl Ahmad of the Central Training College, Lahore, Pakistan; Yaotun Wu, a teacher at Tapei City, Formosa.



Scout Week brings out the "whole Scout family" at The Training School, one of the few institutions to have all four units — Girl Scouts, Explorers, Boy Scouts, and Cubs.

ALL SCOUT UNITS REPRESENTED AT SCHOOL

During the past month, The Training School at Vineland, N. J. had the distinction of becoming one of the few institutions in the nation to have "the whole Scout family" participating in programs on its grounds.

A new Cub Pack, with 20 young boys as charter members, has been organized. Several months ago, a Girl Scout troop of two patrols was formed. These two additions completed The Training School's Scout family which already had a large Boy Scout troop and two Explorer posts. Nearly 200 youngsters at the school are enrolled in these activities.

The school's Cub Pack committee includes Lewis Hawk, chairman, Bert W. Schmickel, and Thomas B. Keener. Jerry Weisman is Cubmaster and John Mundy Assistant Cubmaster of the new Pack No. 39. Four dens have been formed with Mary Louise Stevens, Barbara E. Ranck, Margaret Dorasavage, and Mrs. Margaret Boag serving as Den Mothers. Dr. Harold A. Delp is institutional representative for the over-all scouting program.

CURRENT PUBLICATION LIST

Recent contributions to professional books and journals from members of the staff at The Training School include:

Harold A. Delp, Ph.D. — Correlations Between The Kent EGY and The Wechsler Batteries, *Journal of Clinical Psychology*, Vol. IX, No. 1, 73-75. January, 1953.

Karl F. Heiser, Ph.D. — Applications of Clinical Psychology to Mental Deficiency, Volume II, Chapter 33, *Progress In Clinical Psychology* by Brower and Abt., NEW YORK: Grune and Stratton, 1952.

Margaret M. Riggs, Ph.D. — Book Review: Behavior Pathology, by N. Cameron and Anne Magaret, CAMBRIDGE, Riverside Press, 1951. *Journal of Abnormal and Social Psychology*, October, 1952, Vol. 47, Pages 860-863.

BOY SCOUT WEEK IS OBSERVED AT TRAINING SCHOOL

The opening of Scout Week was observed at The Training School at the Sunday assembly program on February 8 with all four units of the Scout "family"—Cub Pack, Boy Scouts, Girl Scouts, and Explorers —participating. Dr. Harold A. Delp, institutional representative for the Boy Scouts of America, presided.

After the pledge of allegiance to the flag by the Boy Scouts, the Girl Scouts staged a candlelight ceremony. Principles of Scouting such as the Cub Scout Promise, the Boy Scout Law, the meaning of the Scout Badge, and the Citizenship Pledge were presented by the various units, which now comprise a membership of nearly 200 boys and girls at The Training School.

Choral singing, a bass horn solo, harmonica duets, and a number of readings completed the colorful program.

The following Scout units are now registered at The Training School: Cub Pack No. 39, Boy Scout Troop No. 39, Girl Scout Troop No. 81, and Explorer Posts No. 39 and 139.

SPEAKERS' SCHEDULE

Members of the Speakers' Bureau had a busy schedule during the months of January and February, and seven talks already slated for the month of March. Among the organizations requesting speakers were clubs from Long Branch, Mt. Holly, Vineland, Newfield, Bridgeton, Millville, East Orange, Clementon, Delanco, and Englewood.